TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-16-1726-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bill was denied by the carrier stating preauthorization was not obtained. Reconsideration was submitted but denied or not responded to. We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: $489.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on March 1, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2015	Prescription Medication	$489.96	$489.96

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.503 sets out the fee schedule for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service.
   - 224 – Duplicate charge.
   - D20 – Previously denied by adjuster with PBM.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the total reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes 18 – "EXACT DUPLICATE CLAIM/SERVICE," 224 – "DUPLICATE CHARGE," and D20 – "PREVIOUSLY DENIED BY ADJUSTER WITH PBM." Review of the submitted documentation finds one Explanation of Benefits dated May 29, 2015. Submitted documentation does not include any previous reviews or denials. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503(c), which states, in relevant part:

   > The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   > (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   > (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount…
   > (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   > (A) health care provider…

   The requestor is seeking reimbursement for the generic drugs Baclofen, NDC 38779038809; Amantadine, NDC 38779041105; Gabapentin, NDC 38779246109; Amitriptyline, NDC 38779018904; and Bupivicaine, NDC 38779052405. The disputed medication was dispensed on March 30, 2015. The reimbursement is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
3/30/15	Baclofen	(35.630 x 5.4 x 1.25) + $4.00 = $244.50	$184.68	$184.68	$0.00	$184.68
3/30/15	Amantadine	(24.225 x 3.0 x 1.25) + $4.00 = $94.84	$38.46	$38.46	$0.00	$38.46
3/30/15	Gabapentin	(59.850 x 3.6 x 1.25) + $4.00 = $273.33	$188.10	$188.10	$0.00	$188.10
3/30/15	Amitriptyline	(18.240 x 1.8 x 1.25) + $4.00 = $45.04	$30.70	$30.70	$0.00	$30.70
3/30/15	Bupivicaine	(45.600 x 1.2 x 1.25) + $4.00 = $72.40	$48.02	$48.02	$0.00	$48.02

3. The total reimbursement for the disputed services is $489.96. The insurance carrier paid $0.00. A reimbursement of $489.96 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $489.96.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $489.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 12, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.